DIABETES CARE CENTER

QUESTIONNAIRE

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Name: _____ **Date:** _____

Date of last physical exam: _____

Is this a routine check-up? ☐ NO ☐ YES **If no, list all symptoms you have now:**

1. _____
2. _____
3. _____
4. _____

Other concerns or questions for your doctor:

_____

_____

_____

_____

_____

_____

RELATIVES	AGE	IF LIVING, HEALTH CONDITION	IF DECEASED, AGE AT DEATH	CAUSE
Father				
Mother				
Brother				
Sister				
Spouse				
Son				
Daughter				

HAS ANY BLOOD RELATIVE EVER HAD:	WHO:
Cancer (what kind?):	
Tuberculosis:	
Diabetes:	
Heart trouble:	
High blood pressure:	
Stroke:	
Epilepsy:	
Mental illness:	
Suicide:	
Thyroid disease:	

PLEASE CONTINUE TO THE NEXT PAGE

PATIENT NAME _____ **DATE** _____

Review of systems: check No or Yes for each item. Use the last column for details.

	No	Yes	Notes
• ***CONSTITUTIONAL SYMPTOMS***			
Good general health lately	☐	☐	
Recent weight change	☐	☐	
Fever	☐	☐	
Fatigue	☐	☐	
Headaches	☐	☐	
• ***EYES***			
Eye disease or injury	☐	☐	
Wear glasses/contact lenses	☐	☐	
Blurred or double vision	☐	☐	
Glaucoma	☐	☐	
• ***EARS/NOSE/MOUTH/THROAT***			
Hearing loss or ringing	☐	☐	
Earaches or drainage	☐	☐	
Chronic sinus problem or rhinitis	☐	☐	
Nose bleeds	☐	☐	
Mouth sores	☐	☐	
Bleeding gums	☐	☐	
Bad breath or bad taste	☐	☐	
Sore throat or voice change	☐	☐	
Swollen glands in neck	☐	☐	
• ***CARDIOVASCULAR***			
Heart trouble	☐	☐	
Chest pain or angina pectoris	☐	☐	
Palpitation	☐	☐	
Shortness of breath with walking or lying flat	☐	☐	
Swelling of feet, ankles or hands	☐	☐	
• ***RESPIRATORY***			
Chronic or frequent cough	☐	☐	
Spitting up blood	☐	☐	
Shortness of breath	☐	☐	
Asthma or wheezing	☐	☐	
• ***GASTROINTESTINAL***			
Loss of appetite	☐	☐	
Change in bowel movements	☐	☐	
Nausea or vomiting	☐	☐	
Frequent diarrhea	☐	☐	
Painful bowel movements or constipation	☐	☐	
Rectal bleeding or blood in stool	☐	☐	
Abdominal pain	☐	☐	
Peptic ulcer (stomach or duodenal)	☐	☐	
• ***GENITOURINARY***			
Frequent urination	☐	☐	
Burning or painful urination	☐	☐	
Blood in urine	☐	☐	
Change in force of stream when urinating	☐	☐	
Incontinence or dribbling	☐	☐	
Kidney stones	☐	☐	
Sexual difficulty	☐	☐	
Male - testicle pain	☐	☐	
Female - pain with periods	☐	☐	
Female - irregular periods	☐	☐	
Female - vaginal discharge	☐	☐	

	No	Yes	Notes
• ***MUSCULOSKELETAL***			
Joint pain	☐	☐	
Joint stiffness or swelling	☐	☐	
Weakness of muscles or joints	☐	☐	
Muscle pain or cramps	☐	☐	
Back pain	☐	☐	
Cold extremities	☐	☐	
Difficulty in walking	☐	☐	
• ***INTEGUMENTARY (skin, breast)***			
Rash or itching	☐	☐	
Change in skin color	☐	☐	
Change in hair or nails	☐	☐	
Varicose veins	☐	☐	
Breast pain	☐	☐	
Breast lump	☐	☐	
Breast discharge	☐	☐	
• ***NEUROLOGICAL***			
Frequent or recurring headaches	☐	☐	
Light headed or dizzy	☐	☐	
Convulsions or seizures	☐	☐	
Numbness or tingling sensations	☐	☐	
Tremors	☐	☐	
Paralysis	☐	☐	
Stroke	☐	☐	
Head injury	☐	☐	
• ***PSYCHIATRIC***			
Memory loss or confusion	☐	☐	
Nervousness	☐	☐	
Depression	☐	☐	
Insomnia	☐	☐	
• ***ENDOCRINE***			
Glandular or hormone problem	☐	☐	
Thyroid disease	☐	☐	
Diabetes (note insulin or non-insulin)	☐	☐	
Excessive thirst or urination	☐	☐	
Heat or cold intolerance	☐	☐	
Skin becoming dryer	☐	☐	
Change in hat or glove size	☐	☐	
• ***HEMATOLOGIC/LYMPHATIC***			
Slow to heal after cuts or injuries	☐	☐	
Bleeding or bruising tendency	☐	☐	
Anemia	☐	☐	
Phlebitis	☐	☐	
Past transfusion	☐	☐	
Enlarged glands	☐	☐	
• ***ALLERGIC/IMMUNOLOGIC***			
History of skin reaction or other adverse reaction to:			
Penicillin or other antibiotics	☐	☐	
Morphine, Demerol or other narcotics	☐	☐	
Novocain or other anesthetics	☐	☐	
Aspirin or other pain remedies	☐	☐	
Tetanus antitoxin or other serums	☐	☐	
Iodine, methiolate or other antiseptic	☐	☐	
Other drugs/medications	☐	☐	
Known food allergies:			
Environmental allergies:			

PLEASE CONTINUE TO THE NEXT PAGE

Patient Name: _____

PERSONAL HISTORY

Illnesses

Have you ever had any of the following: (please check next to the ones you've had or have)

- ☐ **Measles:** _____
- ☐ **Mumps:** _____
- ☐ **Chickenpox:** _____
- ☐ **Epilepsy:** _____
- ☐ **Stroke:** _____
- ☐ **Glaucoma (Last eye exam):** _____
- ☐ **Cataract:** _____
- ☐ **Rheumatic Fever:** _____
- ☐ **Heart Disease:** _____
- ☐ **Congestive Heart Failure:** _____
- ☐ **Pneumonia:** _____
- ☐ **Asthma or Hay Fever:** _____
- ☐ **Emphysema/COPD:** _____
- ☐ **Tuberculosis:** _____
- ☐ **High Blood Pressure:** _____
- ☐ **Gallbladder Disease:** _____
- ☐ **Sleep Apnea:** _____
- ☐ **Hepatitis:** _____
- ☐ **Fatty Liver:** _____
- ☐ **Stomach or Duodenal Ulcer:** _____
- ☐ **Colon or Bowel Trouble/IBS:** _____
- ☐ **Kidney Disease:** _____ **Stage:** _____
- ☐ **Bladder:** _____
- ☐ **Anemia:** _____
- ☐ **Diabetes:** _____
- ☐ **Thyroid Disease:** _____
- ☐ **Thyroid Nodules/Goiter:** _____
- ☐ **Hives or Eczema:** _____
- ☐ **Anxiety:** _____
- ☐ **Depression:** _____
- ☐ **High Cholesterol:** _____
- ☐ **Cancer/Type:** _____
- ☐ **High Calcium:** _____
- ☐ **Pancreatitis:** _____
- ☐ **Osteoporosis:** _____
- ☐ **Low Testosterone:** _____
- ☐ **Polycystic Ovary Syndrome (PCOS):** _____
- ☐ **Any Other:** _____

Hospital

Have you ever been hospitalized for any illness, including surgery? *(Give details and dates.)*

Allergies

Are you allergic to any:

Drugs: _____

Foods: _____

Other: _____

Current Medications:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____

Past Medications You Have Taken:

- ☐ **Insulin:** _____
- ☐ **Thyroid:** _____
- ☐ **Blood Pressure Medication:** _____
- ☐ **Tranquilizers:** _____
- ☐ **Birth Control Pills:** _____
- ☐ **Hormone Pills:** _____
- ☐ **Other:** _____

Diabetes Devices

Insulin pump:	☐ NO	☐ YES	Brand/model: _____
Continuous glucose monitor (CGM):	☐ NO	☐ YES	Brand/model: _____
Blood glucose meter:	☐ NO	☐ YES	Brand/model: _____

PLEASE CONTINUE TO THE NEXT PAGE

Patient Name: _____

SOCIAL HISTORY

Have you ever smoked? ☐ NO ☐ YES Do you smoke now? ☐ NO ☐ YES How many per day? _____

If you quit, when? _____ At what age did you start? _____

Do you drink alcoholic beverages? ☐ NO ☐ YES How much? _____

Are you on a special diet? ☐ NO ☐ YES If yes, what kind of diet? _____

Height: _____ Weight now: _____ One year ago: _____

States and countries in which you have lived? _____

When did you move to Florida? _____

Previous occupations: _____

Have you ever had an EKG? ☐ NO ☐ YES If yes, date of last one: _____

Have you ever had a chest x-ray? ☐ NO ☐ YES If yes, date of last one: _____

DEVICES

Do You Use...?

Eyeglasses	☐ NO	☐ YES	Hearing Aids	☐ NO	☐ YES	IUD	☐ NO	☐ YES
Contact Lenses	☐ NO	☐ YES	Dentures	☐ NO	☐ YES	Others: _____		

WOMEN

Menstrual History:

Age at onset: _____ ☐ Regular ☐ Irregular Last menstrual period: _____

Have you gone through menopause? ☐ NO ☐ YES If yes, at what age? _____

Date of last pap smear or pelvic exam: _____

Have you ever had a mammogram? ☐ NO ☐ YES If yes, date of last one: _____

Pregnancy:

How many times pregnant? _____ Full term: _____ Premature: _____

Miscarriages: _____ Terminations: _____ Living children: _____

Birth defects: _____

Any complications with pregnancy? _____

Date of last childbirth: _____

Any other information you would like to list:

_____

_____

_____

_____

For office use only — Doctor's initials: _____